Missed Appointment Follow Up

This form is to be used when your office has a patient 20 years of age and under, on Medicaid or CHP+, and would like a Family Health Coordinator to contact the family and help resolve a problem due to a missed appointment or unnecessary Emergency Department (ED) visit. We will provide your office with an update to the discussion we had with the family if we are able to reach them with the contact information you provide us.

Tri-County Health Department
Healthy Communities Fax: 303-745-3365
Healthy Communities Phone: 303-873-4404
E-mail: healthycommunities@tchd.org
Missed Appointment and Unnecessary ED Referral Sheet

Return form to:
Healthy Communities Outreach Team
Tri-County Health Department (Adams, Arapahoe, Douglas, Elbert Counties).
Fax: 303-745-3365   Phone Number: 303-873-4404

This form is utilized for missed appointments or to report an unnecessary Emergency Department (ED) visit for patients ages 0-20 years with Medicaid or CHP+.

Please fill out form as completely as possible. Thank you!

Clinic/Provider Information

Provider Name:_______________________________________________________

Provider Phone Number:_____________________________ Provider Fax:______________

Missed Appointment: □  Unnecessary ED visit: □  Detailed Reason for Referral

________________________________________________________________________

Guardian Information

*Name:_________________________________________  *Phone #_____________________

*Address:

*County: ____________________________  *Zip Code: __________ Medicaid #_____________________

Childs Information

*Name:_________________________________________  *Child’s Date of Birth: __________

*Child’s Medicaid #_______________________  Family E-mail address:_____________________

Family Health Coordinator Report

Date Worked:  
Action Taken:__________________________________________________________
Outcome of Action:

Date Worked:  
Action Taken:__________________________________________________________
Outcome of Action:

Date Worked:  
Action Taken:__________________________________________________________
Outcome of Action:

Family Health Coordinator:

Location:

Phone Number:________________________________ Fax Number: 303-745-3365

Date Received:

Date Completed:

Follow-Up call to provider date:

☐ Please Check Here if you would like a follow-up report after we contact (or make 3 attempts to contact) the client.